Montana Mental Health Nursing Care Center

Resident Rights Grievance Report Form

Resident Name: _____ Received Date: _____

Right you feel has been violated, or nature of complaint:

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_____

Date: _____ Resident's Signature: _____

Investigation and Action taken by Resident Rights Advocate:

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_____

Date**:** _____ Advocate Signature: _____

Superintendent Review and Conclusion:

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_____

Date Provided to Resident:_____

Date: _____ Superintendent's Signature**:** _____

This grievance is/is not confirmed. Corrective action was/was not taken by the facility: (describe):

_____